STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 12, 2018

Bruce Cummings, Administrator
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Dear Mr. Cummings:

Unannounced visits were made to Lawrence & Memorial Hospital on March 16 and 19, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by April 26, 2018 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

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DATES OF VISIT: March 16 and 19, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Respectfully,

Heidi Caron, M.S.N., R.N., B.C., C.L.N.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:lst

CT #22959

DATES OF VISIT: March 16 and 19, 2018

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6) and/or (j) Emergencies.

1. Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient # 1) known to be in the custody of the Department of Children and Families (DCF), the facility failed to protect a vulnerable patient when a high risk situation presented and/or failed to initiate the abduction response plan timely resulting in the patient being abducted by a non-custodial parent and an unauthorized person. The findings include:
   a. Patient #1 (aged 3 years old) was admitted to the ED on 2/13/18 at 11:07PM. Patient #1 was accompanied by Person #1(non-custodial parent) and a female (Person #2). Person #1 alleged possible sexual abuse to Patient #1 by a family member who has custodial rights assigned by another state. It was determined that the child resides in the state of Connecticut with the family member with CT DCF involvement. Review of the clinical record notes dated 2/13/18 from 11:07PM to 11:54PM identified the patient had a history of fever in the last four hours, initial assessments were negative and a documented Temperature 102.9 F. Review of the ED notes dated 2/14/18 identified communication with DCF personnel and the local police department. The notes further identified DCF requested Patient #1 to remain at the hospital until their arrival at which point a safe place for discharge will be determined. Review of the clinical record note dated 2/14/18 at 1:23AM identified the sexual assault victim assessment identified normal appearance of vaginal and rectal area. Review of the ED notes dated 2/14/18 at 9:00AM identified RN#1 assumed charge of Patient #1 and RN#1 communicated with DCF to ascertain arrival time but no specific time was given. Review of the clinical record identified hourly rounding from 2/14/18 12:44AM to 2:30PM with Person#1 continuously updated on plan of care and informed that Patient #1 cannot leave until DCF arrives. Review of the ED notes dated 2/14/18 at 2:31PM identified Person#1 requesting to leave and indicating that he/she has daytime custody of Patient#1. Further review identified that the DCF caseworker was notified via voicemail message of Person#1's intention. On 2/14/18 at 3:12PM, Person #1 demanding to leave, MD#1 was notified by RN#1 of the situation. Review of the ED provider notes dated 2/14/18 by MD#1 identified RN#1 informed him/her that Person #1 had become agitated and requesting that Patient#1 be discharged. MD#1 went into Patient#1's room and noted that Person#1 became angry and yelling towards her. MD#1 could not locate Patient #1 in the room and inquired as to where he/she was. Person#1 refused to disclose the location of Patient#1.

      Review of the video footage with the Public Safety Manager on 3/16/18 at 1:00PM identified the following staff interaction and activity with Patient#1 on 2/14/18 from 3:10PM to 3:23PM: 3:10PM Person#2 in hallway using cell phone near Patient#1's room, 3:12PM Person#2 is seen carrying Patient#1 walking away from the nursing station towards a back exit leading into the waiting room area. At 3:14pm, Person#2 is seen carrying Patient#1, walks past the assigned public safety officer, exits the ED via the main entrance and is seen making a right turn towards the parking garage. At 3:18PM, MD#1 leaves

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Patient#1's room and walks towards the nurses' station. Person #1 leaves Patient#1's room walking away from the nursing station towards a back exit leading into the waiting room area and at 3:19PM Person#1 is seen walking through the waiting room. At 3:20PM, two public safety officers are conversing near the ED main entrance. Person #1 walks past the officers and exits the ED walking towards the street.

At 3:21PM, RN#1 is seen talking to the public safety officer assigned by the main entrance. At 3:21PM, MD#1, public safety officer and RN#1 exit the ED via the main entrance and at 3:22PM, MD#1, public safety officer and RN#1 return into the ED.

Review of the facility Adverse Event investigation identified the internal code amber alert was initiated at 3:24PM by RN#1; 5 minutes after Person#1 was identified to have left the room.

Review of the clinical record dated 2/16/18 identified Patient #1 returned to the ED at 11:45PM by the local police for medical examination. Review of facility documentation identified the examination results were negative and the patient was discharged on 2/17/18 into the custody of DCF personnel.

Interview with the Public Safety Manager on 3/16/18 at 1:00PM, identified that a public safety officer is positioned outside the ED at the main entrance and another officer is positioned inside the ED for the crisis unit area at all times in addition to the officers being replaced every hour.

Interview with RN #1 on 3/19/18 at 11:05AM identified when he/she assumed charge of Patient#1 and was aware of Person#1's custodial status and that Person#1 was calm and co-operative when he/she interacted with him/her. RN#1 stated that he/she informed MD#1 that Person#1 was becoming frustrated and appeared agitated because of the delayed arrival of DCF personnel. RN#1 further identified that he/she did not inform a public safety officer of Person#1's changed behavior and did not believe Person#1 was a flight risk.

Interview with MD#1 on 3/19/18 at 11:50AM identified that RN#1 continuously updated his/her on the status of Patient#1 and initially there were no concerns with Person#1. MD#1 identified RN#1 informed his/her that Person#1was becoming agitated and as he/she entered Patient#1's room to introduce herself to Person#1 'stepped up to me'. MD#1 further identified Patient #1 was not in the room and upon inquiry and Person#1 declined to tell him/her where the patient was. MD#1 stated that he/she told Person#1 to remain in the room, went to the nurses' station, directed the secretary to call security and initiate the amber alert and also notified the public safety officer who was in close proximity. Upon return to the room, MD#1 stated Person#1 was not present.

Interview with the Interim Director of the ED on 3/19/18 at 1:50PM identified when a patient who has been identified as a DCF client and is in a hold status the expectation is to expedite a plan of care to ensure safe and appropriate disposition. This would include

optimal placement in the department, away from any exits and utilizing a sitter and/or observation guidelines. The interim Director of ED further identified in a high risk situation e.g. a person's behavior is escalating the primary nurse and MD should inform the charge nurse immediately to initiate awareness of a potential situation.

Review of the facility abuse identification and reporting policy identified in part that any physician examining a child suspected of being abused may keep the child in the custody of the hospital for no longer than 96 hours.

Review of the code amber abduction response plan identified in part that the purpose is to provide a rapid, organized and thorough response to suspected or actual infant/child abduction.

On 2/15/18, an immediate action plan regarding internal amber alert, pediatric patients on 96 hour hold and high risk patients in the ED was developed and implemented by the hospital. The plan identified all staff and personnel involved with the ED were educated, revision of policies, development of a pediatric patients on 96 hour hold algorithm, implement high risk patient log communication for security and code amber drills to be conducted and completed by 3/26/18.